

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/20/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST VINCENT HOSPITAL &amp; HEALTH SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2001 W 86TH ST</b> <b>INDIANAPOLIS, IN 46260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State complaint.</p> <p>Complaint: IN00138960 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 12-19 &amp; 20-13</p> <p>Facility number: 005075</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>St Vincent Hospital &amp; Health Services is in compliance with 410 IAC 15-1.5-5, Medical Staff, 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules.</p> <p>QA: cloughlin 01/03/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE